Texas Department of Insurance
Division of Workers' Compensation
Medical Fee Dispute Resolution, MS-48
7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645
512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

COMPLIANCE TOXICOLOGY LLC
25810 OAK RIDGE DRIVE
THE WOODLANDS TX 77380

Respondent Name
NEW HAMPSHIRE INSURANCE CO

Carrier's Austin Representative
Box Number 19

MFDR Tracking Number
M4-13-1026-01

MFDR Date Received
December 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The attached bill was denied by your company, however no adequate denial rational was furnished on the attached EOB. We would note that your failure to supply a denial rationale is a violation of Tex. Lab. Code §408.027(e) in that you have failed to 'send to the division, the health care provider, and the injured employee a report that *sufficiently explains* the reason for the reduction or denial of payment.' (Emphasis Added.)"

Amount in Dispute: $1,245.00

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "ESIS maintains its denial of services billed for 01/10/2012 as the claim was adjudicated as non-compensable and the denial was affirmed through a Benefit Contested Case Hearing and upheld by the Appeals Panel."

Response Submitted by: ACE, ESIS

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
January 10, 2012	G0431 x 5, 82570, 83986, 36415, 80154, 80299 x 2, 82145, 82205, 82520 x 2, 83840 x 2, 83925 x 2, 83992 x 2	$1,245.00	$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving disputes regarding the amount of payment due for health care determined to be medically necessary and appropriate for treatment of a compensable injury.
2. 28 Texas Administrative Code §133.305 sets out the general procedures for resolving medical disputes.

3. The services in dispute were reduced/denied by the respondent with the following reason codes:
   Explanation of benefits
   - A1 – Claim/Service denied

Issues

1. Have the relevant extent of injury issues been resolved?
2. Is the requestor entitled to reimbursement?

Findings

1. 28 Texas Administrative Code §133.305(a)(4) defines a medical fee dispute as a dispute that involves an amount of payment for non-network health care rendered to an injured employee (employee) that has been determined to be medically necessary and appropriate for treatment of that employee's compensable injury.

   28 Texas Administrative Code §133.305(b) requires that "if a dispute regarding compensability, extent of injury, liability, or medical necessity exists for the same service for which there is a medical fee dispute, the disputes regarding compensability, extent of injury, liability or medical necessity shall be resolved prior to the submission of a medical fee dispute for the same services in accordance with Labor Code §413.031 and 408.021."

   The services in dispute were denied, due to unresolved extent of injury issues. The issues raised and relevant to the services in this medical fee dispute involved whether the compensable injury arose out of an act of a third person intended to injure the claimant because of personal reasons and not directed at the claimant as an employee or because of the employment, thereby relieving the carrier of liability for compensation. A contested case hearing was held and a decision was issued on September 19, 2012. In its decision, the division concluded that the claimed injury arose out an act of a third person intended to injure the claimant because of personal reasons and not directed at the claimant as an employee or because of the employment, thereby relieving the carrier of liability for compensation. The division finds that the relevant compensability issue was resolved.

2. The division concludes that the services in dispute were rendered by the requestor to treat an injury found to be non-compensable according to the Contested Case Hearing decision discussed above. For that reason, no reimbursement can be recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is $0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to $0.00 reimbursement for the disputed services.

Authorized Signature

Signature	Medical Fee Dispute Resolution Officer	October 9, 2013 Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, *37 Texas Register 3833*, **applicable to disputes filed on or after June 1, 2012**.

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).